suicidal	67%
selfharm	4%
runaway	4%
aggressive	25%

January	9%
february	25%
March	31%
April	7%
May	27%

8 am-12 nc	27%
noon-5pm	39%
5 pm-12 m	34%

Funding source

BCBS	12%
CHIPS	4%
medicaid	60%
medic +insı	3%
none/unkn	13%
other insur	7%

Source of Referral

benefis	69%
b-pediatric	3%
Schools	15%
GFPD	7%

Crisis Diversion Data **70 + kids**

52% female

37% diagn unknown | **64%?**

27% no diagnosis

64% medic or chips

70% were diverted

70% over age 12

24% age 10 and under

23% involved w/CFS

CHILDREN & FAMILIES
June 25, 2014
Exhibit 14

Community Concern: Emotional Disturbance and Crisis in the Lives of many Youth

What's the need?

Crisis response and immediate access to services for youth in emotional crisis are an area of extreme need in the State of Montana. Due to both the emotional impact on families and youth and the unpredictable financial impacts to local and state budgets we must take a critical next step for communities to address, requiring a collaborative effort, an array of options, and adequate, accessible funding for effective services. The cost of developing such an improved crisis response system will be offset by the lives saved and the money saved when considering the cost of youth being served out of their home community in higher levels of care across systems, both in-state and out-of-state. Even more it is an investment in the future of each child who faces such hard and traumatic emotional challenges.

What is the nature of crisis?

When children experience psychiatric and/or behavioral health crises, it is often a crisis for the parent as well. Parents managing difficult behaviors become exhausted with day to day matters, often attempting to manage it on their own for a variety of reasons: fear of inadequacy and failure as a parent, embarrassment at what their child and family is experiencing, lack of adequate insurance to cover needed services and supports, lack of information about what is available, and fear that their child's needs will surpass their ability to provide care in their home. Everyone suffers rather than anyone getting stable.

Many families turn to external help only when feel they are out of options. Often this is too late and too little. This commonly results in expensive visits to an Emergency Room or police intervention and criminalization of the youth. Because both of these resources are emergent, the priority is to establish safety quickly with a brief snapshot of information about the child's behavior and needs. It is an easy pathway from here to longer term, higher cost facilities such as inpatient hospitalization, residential treatment, or detention due to crisis-driven decision making and the lack of other immediate options. Once this pathway is established, it becomes an easier decision the next time, and perhaps the time after that thus costing more and not solving anything.

What are the options?

Currently, if a youth is deemed in need of acute stabilization, there are the following options in the State: The Providence Center in Missoula, Shodair Children's Hospital in Helena, Billings Clinic, and Pathways Treatment Center in Kalispell. These facilities serve adolescents, with Shodair Children's Hospital and Billings Clinic the options in the state for youth under 12. Residential, longer term psychiatric care is offered by Shodair Children's Hospital in Helena, Yellowstone Boys and Girls Ranch in Billings and Acadia in Butte. If these facilities are full, youth needing this care are placed out of state. Out of state placements make it difficult for parents to be meaningfully involved in their child's day to day care and progress, and preclude the ability to address issues the child experiences in the home, where many of the issues originate.

This presents a distressing decision for parents, to either admit their child to a facility that may be hundreds of miles away or to try to manage the crisis with limited community options. These options include traditional community based mental health services that may take weeks to set up, and may not provide the level of intensity needed to stabilize the child at home. These services are not yet designed to provide crisis response!

A viable community based option would be providing the option of a short term stay at a youth shelter, therapeutic group home or specially trained foster home. They could be utilized if the you comes under the jurisdiction of youth courts, child protective services or youth **probation**.

Many of these youth do not present serious delinquency issues nor have suffered profound abuse. Rather, they have a need for a limited intervention that can help them stabilized and return to their homes. Unfortunately youth without Medicaid have even fewer community-based options. Commonly, they only have access to outpatient therapy and inpatient care, as well as the potential for youth court or child protective services involvement if these are not successful

What are the numbers?

According to the Children's Mental Health Bureau, **56 youth were placed out of state** in Fiscal '12 at a cost of $3,007,848. The average length of stay in an out of state facility was 291.5 days in 2012, compared to the length of stay in an in state facility of 115.6 days in 2012. From July 1, 2013 through December 30, 2013, 26 youth were placed in out of state psychiatric residential treatment facility, 14 were placed in out of state therapeutic group home, and 5 were placed in out of state non-therapeutic placements. These numbers comprise placements by all state agencies and divisions, a total of **45 youth in the first half** of this fiscal year. Contributing factors related to out of state placement include lack of bed availability, lower levels of care unavailable at the time of admission, and history of multiple placements without a clear response to treatment.

What is the solution?

"Crisis response services" propose to create successful outcomes primarily through early intervention close to home. These services might include "immediate" case management/facilitation response, evaluation and assessment, residential crisis stabilization in the community (again may vary from community to community with options of shelter group homes, therapeutic group homes, or foster care designed to clearly address crisis stabilization) for up to 14 days, and a mobile crisis response team inside of and outside of "regular business hours." These services are meant as an a la carte menu for community around which it can develop a unique response tailored to local needs and community cultures.

Crisis Case Management/Facilitation: Crisis case management/facilitation begins with a youth and family in crisis within 24 hours of identification and provides up to 15 hours or 30 days of service. This consists of assessment of strengths and needs, exploration of crisis behavior/situation, development of a safety plan, appropriate referral and linkage, and teaching family skills to anticipate and plan for future crises.

Evaluation and Assessment: Evaluation and assessment includes specialized assessments like the Child and Adolescent Needs and Strengths (CANS) or more general assessments to determine risk and eligibility for follow up services.

Short-term Residential Crisis Stabilization: Short-term residential crisis stabilization consists of placements designed to specifically address crisis and bring the family along to facilitate replacement back home whenever possible. This proposes presumptive eligibility for 3 days to insure safety above all, including financial responsibility, and for a period of up to 14 days if needed.

Mobile Crisis Response Team: Mobile crisis response consists of qualified individuals who can respond to youth in crisis outside of regular business hours with the intent of assessing whether youth requires emergency care or whether the crisis can be stabilized at the scene with de-escalation strategies, a safety plan, other available crisis services, and appropriate follow up. The costs for such teams are high and there is a need to consider a coordinated and shared effort in communities to develop such response in the youth and adult mental health systems.

What would the savings be?

As discussed, decisions made in crisis with few options often leads to expensive, perhaps unnecessary, placements. Once a youth leaves their home and/or community in crisis, this becomes the default solution for future crisis. Consider that an in-state PRTF costs approximately $310.00 per day, with acute and out of state rates significantly higher.

If a child were to receive mobile crisis response, 14 days of shelter and 30 days of crisis case management/facilitation, this would cost the equivalent of a 14 days at an in-state Psychiatric Residential Treatment Facility and less than 10 days in an out-of-state treatment program. It would, instead, keep a child in the community, intensely engage the whole family in the process, ensure transition to local resources, and ultimately prevent the beginning or continuation of a cycle of institutionalization that many experience through their entire lives, costing an enormous amount of public funding in the long run.